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Clinical Lectures.

DISEASES OF THE JOINTS IN HÆMOPHILIACS, WITH SPECIAL REFERENCE TO DIAGNOSIS.

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Gentlemen:—Under the manifestations of that most peculiar and problematic disease, hæmophilia, there is not one perhaps that is of such importance to surgeons as that of bleeding into the synovial sac. While many chapters relating to hæmophilias, as for instance its ætiology, are still surrounded by the darkness of uncertainty, and the history of the disease in the family and its heredity is in no way understood, yet the clinical histories of those conditions of the joints, which we all want to designate as "bleeding joints" are very accessible, and may be easily obtained. To be sure it was a long time before the articular affection so common to hæmophiliacs, was recognized as a repeated bleeding into the synovial sac, or as a "bleeding joint."

The older authors of this century who have occupied themselves with this question, had a variety of opinions concerning both the nature and origin of the disease. Many attributed them to gout, a disease which they had opportunity of seeing a great deal of. Indeed, the knowledge of diseases of the joints being at that time very crude, nearly all such fell under the above heading. Some physicians, who had enjoyed larger experience recognized different varieties.

So Elsässer speaks of the gouty joints, but tells also of a patient, in whom after one joint became affected, developed a "*tumor albus*" at the knee, which after suitable treatment, such as rest and blisters, was ultimately cured.

We will see that Elsässer recognized various stages of the disease with correctness.

Wachsmuth, during the forties, was unable to see any difference between bleeding joints and articular rheumatism. He spoke of the disease in the joint as pseudo-rheumatism, and *rheumatismus spurius.*

Lange, in 1851, took a similar view of the affection. He interprets Elsässer's *tumor albus,* as a rheumatic tumor, with now greater and now less inflammatory manifestations. Finally, Grandidier, the physician and writer who made so extended a study of hæmophilias, in a monograph published in the seventies, ascribed the articular affections of hæmophiliac subjects to either gouty or rheumatic origins.

It was first during the sixties, that a few surgeons leaned towards the idea that the articular diseases in bleeders, at least in part, was due to a bleeding into the joint.

Richard von Volkmann, in his magnificent work on the diseases of the bones and joints, which appeared in 1868, said that both in hæmophilias and scorbutis, hæmarthrosis occurred either spontaneously or else with but very slight exciting cause. Reinert endeavored to prove most emphatically by the history of a very interesting case that the great majority of cases of bleeding-joints could be traced to intra-articular hæmorrhage.* Most emphatically also Lossen endeavored to turn aside the current idea of a uric acid diathesis or rheumatism in the bleeders. He explained that the "bleeders" joint was due to hæmorrhage into the synovial sac, and disturbance caused by this.

It is necessary thus to review the

*From *Volkmann's Collection of Clinical Lectures,* delivered before the Society of Natural Scientists, at Halle.

*Göttinger, 1869.

history of this disease in order to understand why it is yet, even among specialists, comparatively little known. The rarity of its occurance alone does not explain this.

As long as the profession remained of the opinion that bleeders were subject to various rheumatic, arthritic and other diseases of the joints, it did not seem worth the while to investigate these forms of otherwise well-known diseases. The question, however, assumed an entirely different aspect, when it was learned that the articular diseases of bleeders were entirely characteristic and distinct from others, and that their study offered a most interesting field for pathologico-anatomical research. Furthermore, that under certain circumstances their clinical study will enable the physician, from the character of the disease, to diagnose the hæmophilias as well as the bleeder's-joint, and many important points regarding the treatment may also be gleaned.

We are of the opinion that if physicians had a thorough understanding of the matter, it would be seen that the "bleeder's joint" was not such a rare affection as had been thought; especially may this be true since the clinical picture presented would almost justify a diagnosis of *tumor albus* (white swelling,) or articular tuberculosis. The possibility of such a diagnostic error can, as one can readily see, be a fatal mistake to the bleeder. Out of 8 bleeders with bleeder's-joints, which were treated during the last ten years at the clinic in Göttingen, two died from the results of a mistaken diagnosis, a surgical operation, for the relief of their condition having been attempted.

The object of this lecture is a practical one. It is designed to furnish the profession with a guard against similar mistakes to the above, which occurred to the writer.

Anyone who has stood helplessly by the bleeding operative wound of a hæmophiliac subject, and who has been forced to endure the sight of seeing such a subject die, before his very eyes, from a wound which he has inflicted with the best intentions—such a one will gratefully acknowledge the attempt that is made here; at least the attempt to render the diagnosis of bleeder's-joint a matter of possibility, if not certainty, in many cases.

The peculiar manifestations of a bleeder's-joint, not only those which occur at the first appearance of the hæmorrhage, but the many changing symptomatic pictures which occasionally assume a very chronic course, and are caused by the repeated hæmorrhages in the joint or joints.

To the hæmorrhages are added motor disturbances, and these, as we shall presently see, give rise to a typical inflammatory condition of the joint, which later may result in a loss of the joint, severe contractures, ankyloses, and great deformity.

According to this, we are justified in dividing the joint disease of the hæmophiliacs into three stages. The first stage is that of the first hæmorrhage into the joint. The clinical picture of this stage is that of a true hæmarthrosis. Of course, in certain cases and under certain circumstances the disease can end also with this stage, that is, the hæmarthrosis may be cured. If this is not the case the presence of the blood causes irritation, and there develops a peculiar form of inflammation, which develops as a panarthritis, and the pathalogico-anatomical as well as the clinical manifestations greatly resemble those of tuberculosis of the joint, especially that variety which is known by the name of *hydrops tuberculosus fibrinosus*. This stage might well be designated as the inflammatory stage, and it is certainly that stage which former authors have designated as white swelling, or *tumor albus*.

The third stage includes those regressive metamorphoses of the joint; the stage of pathological change of the joint, of adhesions, of displacement of the articular surfaces, of contractions, of ankylosis, and of deformities of the joint.

In brief, therefore, we can divide the course of the disease as follows:

1. The stage of the first hæmorrhage—the hæmarthrosis of bleeders.
2. The stage of inflammation—the panarthrosis in the bleeder's-joint.
3. The regressive stage—the stage which leads to permanent deformities of the bleeder's-joint—the contracted bleeder's-joint.

If we now turn to a consideration of the clinical manifestations of the bleeder's-joint, it need scarcely be said that a hæmorrhage which occurs spontaneously does not conduct itself with any material difference from one which is caused traumatically as is a rule, however, there is no traumatism in the case of the bleeders, and there must

be other grounds that will enable us to diagnose a discharge into the joint as a hæmorrhage. In this connetion it must be taken into consideration that the hæmorrhagic discharge into the joint of the bleeders occurs rapidly, similarly as though a traumatism had been effected. In individual cases subcutaneous ecchymoses may appear around the joint, or the green discoloration of the skin near the joint may point to the correct diagnosis. Naturally, the diagnosis will be greatly facilitated if it is previously known that the subject is a bleeder, or belongs to a bleeding family. In this connection I will introduce the clinical history of a patient treated by me during the last term:

Dr. H., seventeen years of age. The man was pale, and a few months previously had developed, quite suddenly, a painless swelling of the knee. The knee was slightly distended, fluctuated plainly and the patella vibrated. Up to the time of examination the patient had been able to use the leg without inconvenience; all normal movements were possible. While I was describing the case to the class, and laying particular stress upon the fact that the pallor of the patient and the sudden appearance of the disease, together with the retention of motor power and painlessness, led me to believe the case one of bleeder-joint, the patient interrupted me by saying, that his physician had cautioned him not to forget to mention that he came from a bleeder family. He himself, he added, bled profusely from the slightest wound and one of his family had a most severe hæmorrhage after the extraction of a tooth.

The trocar evacuated about 100 grammes of fluid blood; a compress was applied, and a protective apparatus made for the patient's knee. He was discharged cured.

As a rule, however, the surgeon does not see this first hæmorrhage, the first step of the disease, but meets with the manifestation described in our second, or inflammatory stage. We have already repeatedly called attention to the fact that the external symptomalogical and clinical picture of the bleeder's-joint is remarkably like that of fibrinous dropsical tuberculosis of the joint.

In the discussion of the pathological anatomy of the disease, the cause of this resemblance will at once be understood. Here we will only say that in both cases we are dealing with an efflux of fluid into the joint, from which fluid fibrinous matter is cast down, which in part remains free in the fluid, and in part deposits itself upon the surface of the joint, and partially, at least, becomes organized. Therefore, in both diseases we find a fluctuating enlargement of the joint with changeable thickening of the synovial membrane.

In the face of these facts one may well be uncertain as to whether it be at all possible to determine upon the correct diagnosis in such cases. We are also of the opinion that under certain circumstances this is impossible. If we know nothing of the history of the case, nothing of the manner in which this questionable disease of the joint has occurred, and above all, have no suspicion that the patient is a bleeder, but only that he has a diseased joint, then, indeed, even the most skillful specialist would fail to diagnose a case presenting the above symptomalogical picture as one of bleeder's joint.

We will now endeavor to discuss such points as may lead to the formation of a correct diagnosis. In the first case, it should be brought forward that youthful subjects, and male subjects at that, are those who are usually subject to the bleeder's-joint. The large majority of male subjects with bleeder's-joints, may be well explained by the large predominance of male bleeders, generally. To this should be added that, as a rule, the patient has a more or less striking paleness of the face. If added to these general symptoms, it happens that apart from the freshly inflamed joint the patient also has one or more deformed limbs that previously have been diseased, or indeed, if while the diagnostician is watching the case, a fresh hæmorrhage into the joint occurs, then the diagnosis of one of the progressive stages of bleeder's-joints becomes greatly strengthened. It becomes almost a certainty when the patient tells us that the first attack came on suddenly in the joint, and that the latter was painless, and primarilly functionally undisturbed, and that the regression has occurred gradually.

All these reasons for assuming the presence of bleeder's-joint, I have unfortunately had to learn through the sad experience of diagnostic mistakes of my own. I

feel that it will be instructive, if I here report the histories of a few of these cases.

In 1880 I received a boy for treatment, thirteen years old, Richard Rose by name. His father had died from consumption. He is said to have been well until about a year and a half before he came under treatment, when he acquired some disease of the left knee-joint. This would first grow better and then worse, but finally the swelling went down, the limb remaining partly flexed, and in a genu-valgum position. Simultaneously the left ankle-joint became diseased and the boy was compelled to walk on the toes of that foot. Three months after the left knee was attacked the right also became diseased. Upon admission the boy's condition was to all appearances that of dropsical tuberculosis of the joints. The joint fluctuated, and there was a knotty, crackling enlargement of the synovialis. During the course of treatment the elbow joint exhibited a passing swelling. No other symptoms of disease were found.

After many attempts to stretch the contracted knee-joint (the left) and to reduce the inflammatory swelling, I proceded to make an incision, feeling confident that I was dealing with a case of articular tuberculosis. The incision revealed the fact that I had to deal with a characteristic bleeder's-joint. I contented myself with draining the joint. On the third day, in spite of all efforts to check the uncontrolable hæmorrhage, the boy was a corpse.

The parents of the boy were both dead, and, therefore, the question of hæmophilias being in the family could not be answered. His mother had died shortly after his birth (from hæmorrhage ?).

The case occurred (in 1880) at a time when as yet I had seen but little of bleeder's-joints. But during the course of the same year I met with a second case and although several manifestations that should have led me to suspect bleeder's-joint were present, I failed to diagnose the case correctly, to the misfortune of the patient. The patient was a very pale boy, eight years old, whose parents were both dead. For three months he had suffered from a diseased knee-joint. The joint had a spindle-formed swelling, in the upper recess of which one could detect obscure fluctuation. A short time before the elbow joint also became swollen. Both joints were painful, and their motion impaired. After many curative attempts, the knee-joint was incised, with a view of resecting it. The first incision revealed clearly the presence of a bleeder's-joint, and in consequence the operation was abandoned, and the joint simply drained. In ten days the patient died from the effects of uncontrollable and repeated hæmorrhages, which persisted in spite of all that could be done.

The experience gained by this case at least sufficiently warned me not to make an incorrect diagnosis in the case of the boy's brother. He was also admitted a few days later, suffering from a joint disease that seemed to be of a tuberculosis origin, with contraction. His right knee was slightly flexed, and in the genu-valgum position, and the medial condyle was very prominent. The synovial swelling was slight. An attempt was made to correct the deformity and to fix the limb in a plaster of Paris bandage. Suddenly both elbows were similarly affected. The boy was eleven years old and very pale. In the meantime the brother had been operated upon and it was learned from evidence obtained from their home that they were from a bleeder family.

In distinction to these cases, the diagnosis of bleeder's-joint was made in the case of a man 23 years old, who simultaneously had tuberculosis (lupus of the face, and tubercular epidydimitis). When ten years old the patient developed a swelling of his left knee-joint. When fourteen years old his right knee became diseased, and while the trouble of the left knee ameliorated the right again became worse and finally ended in contraction and genu-valgum position. Also the left hip-joint had been filled with an effusion, which gradually receded.

I was informed that this patient also belonged to a bleeder family.

During the winter of 1890 to 1891, he was treated with Koch's lymyh for lupus and tuberculous epidydimitis. While the lupus and epidydimitis reacted intensely in response to the injections the joints showed no reaction. Here tuberculin undoubtedly proved that the joints were not tuberculous.

After the above details of symptomatology and diagnostic points, you see that we are in a position very frequently to diagnose the bleeder's-joint. We have already stated that if the disease occurs in the case of a known bleeder, or member of

a bleeder family, that the diagnosis is comparatively easy, and for certainty in such a case, it is only necessary to know that the swelling occurred very suddenly. If one knows nothing of the patients being a bleeder a correct diagnosis can frequently be made. An accurate diagnosis is possible when we meet with rapidly developing enlargements of the joints in pallid youthful subjects; furthermore by the simultaneous characteristics of other joints, and also by the ecchymoses and blue spots which appear upon the body of the patient.

We have gone so far as to show how we can be able to determine upon a correct diagnosis in recent cases of bleeder's-joint after the first hæmorrhage or hæmarthrosis, or after repeated hæmorrhages—panarthritis. On the contrary we have said nothing as to the recognition of the disease in its third or regressive stage.

In order to answer this question, or, indeed, to broaden our knowledge of bleeder's-joint we must look for a few moments at the pathological anatomy of the disease.

This we can do with the aid of two specimens I have at hand, since one can gain but little on the subject in medical literature, and as few if any pathologico-anatomical collections contain specimens of bleeder's joint. My preparations are unfortunately from the two cases that succumbed to my operative interference, and one from a man who lived after such an operation. The findings in each one are identical. All three are from knee joints. One was the subject of a long dissertation by Dr. Bockelmann, as long ago as 1881.

Proceeding from the earlier stages of the disease, the condition which is present a few weeks after the initial hæmorrhage into the joint, we find that the articular space is filled with fluid blood. Apart from this there are some clots, in part discolorized, some floating in the liquid, and others adherent to the capsule. The capsule itself is thickened, succulent, imbibed with blood coloring matter, and therefore discolored accordingly. At some places the fibrinous deposit has begun not only on the capsule but also upon typical places of the surface of the cartilage, sometimes upon the femur, from one side to the other of the upper surface of the cartilage. Here and there brownish pigmented tufts were beginning to form. At this time the cartilage also begins to degenerate, and to become ragged, and sharp-edged peculiar defects appear, which are described below.

The anatomical picture in the second stage of the disease, when it resembles fibrinous dropsical tuberculosis, is similar to the above, save that it is more advanced and greater changes have taken place. The contents of the joint, unless a fresh hæmorrhage has just occurred is not pure blood, but composed of bloody serum, or pure serum of a light brown color. Especially prominent to the eye when such a joint is cut open are the large numbers of floating, brownish, synovial tufts. In the joint of the child who was operated upon and died, the slightly thickened synovial membrane seemed overgrown with moss. In the fluid a large number of delicate brown tufts floated by each other like a Medusa's head, indeed the whole synovial membrane has this appearance, but the discoloration of this membrane varies, sometimes being reddish, brown or gray.

Besides these characteristic changes, the appearance of the surface of the cartilage is none the less peculiar. All over it has lost both its white color and gloss, it is now a dirty reddish-brown or gray. In some cases filiform masses seemed to have raised themselves from its surface, which seem to tend toward the formation of connecting tissue. They are of importance as forerunners of *synechia* in the joint. The principal characteristic changes are sharp-bordered defects of the cartilage, of a map-like appearance, some small and some large. These are found on different parts of the surface of the cartilage, but especially where these filiform masses are seen. Their cause I have not been able to discover. Changes of the articular surfaces of the cartilage, as seen in arthritis deformans are not met with here, although there were unevennesses in the cartilage's surface.

A bleeder's joint does not stay long in this stage, unless additional hæmorrhage occurs. As a rule, after the above anatomical picture the already mentioned regressive changes take place, and the tissues undergo a metamorphosis. There occur adhesions, formations of connective tissue, and contractions with deformity, which need not be further traced. But while the position resulting is not dissimilar to that caused by tuberculosis, yet there is no tendency to the formation of either ab-

scesses or fistulæ; on the contrary, healing often occurs with remarkable rapidity.

The first hæmorrhage into a joint is frequently followed by entire cure, and without leaving any trouble behind it; but I doubt, if the disease has once reached the second stage, that it can ever again become a perfectly mobile joint. To the prognosis must also be added the fact that as the patient is a bleeder, he will very likely get other bleeder's joints.

A fresh hæmartherosis in a bleeder should be so treated that the patient does not use the limb. If a lower limb is affected the patient must not walk, and if an arm is affected he must not use it. But, as a rule, he will disregard this injunction, since the first evidences of the disease are so slight as to be little thought of by the patient.

Moderate compression undoubtedly assists resorption, and I have frequently seen cures result from it.

In the second stage the matter is a different one, and on account of the inflammatory process and pain to the patient the question of operation comes to the fore, and with it the knowledge that we are dealing with a bleeder. I have used puncture in three cases without incurring any serious bleeding, and followed it by irrigation of the joint with carbolic acid solution. Two patients were cured and one improved.

But I would let all operative procedures cease here. Of the three cases in which I, owing to incorrect diagnosis, made an incision into the joint, two died, and one barely recovered.

The contractures may often be helped by plaster of Paris bandages or suitable mechanical appliance. The question "What is to be done in a case of bleeder's-joint?" sinks into utter insignificance in the face of the question "What *not* to do?"

The object of this clinical study is to cause greater familiarity with a not altogether rare disease, but, above all, to save the subject suffering from a bleeder's-joint from untimely death.

ARTICULAR RHEUMATISM.

The following (*Lo Sperimentale*, No. 3, 1892) is recommended as an application in articular rheumatism:

℞ Salol.....gms. 4 (℥j.).
Ether.....gms. 4 (fl. ʒj).
Collodion.....gms. 30 (fl. ℥j).
Apply locally.

Communications.

TREATMENT OF SUMMER DIARRHŒA IN CHILDREN.

By ALICE McLEAN ROSS, M. D.,
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Last summer, while physician to the Woman's Hospital of Detroit, I had exceptionally good results from the following plan of treatment for summer diarrhœa. My infant ward contained on an average forty-five babes, and at one time I had fourteen sick with cholera infantum but I had no deaths from this dread disease during the summer months. As the hot weather is approaching, it is appropriate to discuss this exceedingly prevalent malady.

At the onset of bowel trouble give ʒiss of castor oil to clear out the bowels thoroughly, and after every movement following that caused by the oil, give a teaspoonful of the following mixture:

℞ Bismuth. subnit.....gr. cccxx.
Acid. carbolic.....
Spt. menth. pip.....
Tinct. capsici.....
Spt. camphor.....
Syr. simplic.....
} ää mx.
Aq. cinnamon.....ää qs. ad. ʒviii.

If movements are very frequent, the same dose may be given every 2h. When temperature runs over 102°F. and patient is pretty strong, give acetanilid gr. iss every 3 h. I have observed that the antipyretic effects of this drug last almost exactly 3 hours in children. If patient is weak, lower the temperature by sponge baths, and where fever runs below 102° F, substitute for these, aconite gr. $\frac{1}{75}$, every h. Spirit. frumenti is necessary in small frequent doses where exhaustion supervenes. Give every morning and evening, with soft rubber catheter, a high irrigation of starch water, warm, to which is added ʒss. soda bicarb. to the pint.

Children usually cry a great deal and it is the natural thing for the mother or nurse to give them their accustomed food to stop them. This must not be allowed. They are inclined to drink greedily and overload their already weakened stomachs, and aggravate their trouble. It is best to feed them at their accustomed times only, and give them plain cool boiled water to quench their thirst. Plenty of fresh air

is desirable, and a cool, even temperature is best. Upon very hot days it is well to remove the ordinary clothes and put on a light flannel night dress guarding against sudden changes of temperature, of course. I have tried other plans, but this gave very satisfactory results.

TREND OF MODERN NEUROLOGY*

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ABSTRACT OF REPORT ON PROGRESS IN NEUROLOGY.

Cerebral localization and its utilization for brain surgery is not now as much in the foreground of neurology as it has been in former years. Instead of this neuropathology and anatomy engage the attention of investigators. The "weeding-out" process of the neuroses in noseology is actively and successfully being pushed in the medical centers of the various countries. The number of the purely functional nervous disorders is constantly being diminished by the discovery of their etiological factors and their anatomical substratum. Even "idiopathic" epilepsy, so-called, seems to depend almost always on minute sclerotic patches in the brain which escape detection on naked eye examination. It stands to reason that the rest of the recognized neuroses, hysteria and neurasthenia, will follow suit in the course of time. Bacteriology has been most prominent in making inroads on the supposed functional nervous diseases.

New views and new fields for investigation have been opened by the discovery of the toxines (tetano-toxine, typho-toxine, etc.) and their elective affinity for certain nerve-centers and nerve-tracts.

The toxines led to the discovery of the auto-intoxications, which play such important part in initiative and paralytic nervous diseases.

The knowledge of such pathological conditions, due no doubt to a faulty or perverted metabolism, is of great practical import, affecting principally our notions as to dietetics in disease.

The existence and reality of such auto-intoxications seems to have been demonstrated in the various forms of insanity, in which the urine of the patients greatly exceeds in toxicity that of healthy individuals.

The attempts of some neurologists to annex even such diseases as tuberculosis or cholera, etc., as being nervous diseases, is to be deprecated, being in antagonism to our present accepted nosological and pathological conceptions.

Another divergent movement in neurology is hypnotism as a remedial agent. In the vast majority of cases, where it might perhaps be indicated, simple suggestion does all, and even more than hypnotism and the cultivation of a sanguine temperament in the neurologist will stand very well in place of what is, at best, a species of mummery savoring of and leading to humbuggery. The introduction of hypnosis as such into therapeusis is not to be classed as progress.

* Read before the Mo. State Med. Assoc., May 18, 1892.

CODEINE, ITS PHYSIOLOGICAL ACTION AND THERAPEUTICAL EMPLOYMENT.

Dr. William Heidingsfield, of Strassburg, reports (*Maug. Disser.*) on observations made at the Strassburg Insane Asylum, on twenty-four patients treated with codeine.

The usual dose was 0.02 gramme (⅓ grain) three times a day, in powders or in pills. He found that:

1. Codeine has very little or no anæsthetic action; as a rule, it disappointed in bodily pains, as well as in hysterical disturbances.

2. As a narcotic, it acts better in conditions of depression than in exaltation; but only when given in doses three to four times as large as narcotic doses of morphine. In acute mania, consequently, it is usually without effect.

3. In morphinism, its action is doubtful.

4. Codeine is to be recommended as an extremely prompt sedative in affections of the respiratory tract. It might also be employed where a medicament to quiet and to alleviate pain must be given continuously for a long time; or when a change of remedy is necessary in such cases.

5. Codeine is devoid of any injurious or even merely disagreeable accessory effects, aside from an occasional, slightly itching eruption, which, however, disappears in a few days.—*Merck's Bulletin.*

SOME POINTS IN THE SYMPTOMATOLOGY OF GENERAL PARALYSIS.*

By PHILIP ZENNER, A. M., M. D.,
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After some mention of causes of the disease a brief outline of symptoms was given. The latter are gradual failures of mental powers, attention, judgment, memory, the manifestation of delusions, especially delirium of grandeur, and motor symptoms, paresis of facial muscles, tremor of lips and tongue, a stammering speech, and sometimes spinal paralysis. There are sometimes attacks of acute mania, and paroxysms of an epileptic or apoplectic character. The average duration of the disease is three years. The earliest symptoms are most important to recognize, for if the disease be detected at an early period, financial calamities may sometimes be averted, and it is only then that anything could be hoped from treatment. Ordinarily the disease begins so insidiously that nothing is observed excepting by those coming most intimately in contact with the patient, and by them the changes are not attributed to disease; the early changes are impairment of powers of attention, of judgment, of quick perception, of memory for recent occurrences, etc. The affections become less strong, though the patient may be emotional, cry easily and the like. There is less attention paid ordinary ceremonials, to matters of dress, table manners, etc., and the patient often becomes indecent in his actions. There are usually some objective symptoms, even at an early period, such as tremor of the lips, and in equality of pupils. Spinal myosis is a very early and important symptom. The union of the latter and absent knee-jerks had been often seen in such cases by the writer.

The disease was often supposed to be ushered in abruptly with an attack of acute mania, when changes had taken place long prior to such an attack but their significance had not been recognized. The writer then reported such a case in which the condition of the pupils enabled him to make a correct diagnosis.

*Abstract of the paper read before the Ohio State Medical Society, May 6, 1892.

TREATMENT OF ORCHITIS AND EPIDIDYMITIS.*

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When it is convenient for the patient, or the severity of his case demands that he rests in bed, the scrotum should be supported on a pillow or on a support placed across the thighs. At the beginning of the treatment, a good saline purgative should be administered, preceded by a large dose of calomel if a very active purge is needed. If there is much constitutional disturbance antiphlogistic remedies should be given. Tincture veratrum viride will reduce the heart's action. Acetanilid or phenacetin are useful to reduce the temperature and also relieve the pain to a certain extent. Aconite and antimony are also useful. Phytolacca and pulsatilla are said to have a specific effect in these troubles. Bromide of potash and opium are sometimes needed for rest and relieving pain. Local applications play an important rôle in the treatment, they relieve pain and are necessary to hasten a cure as constitutional remedies. Electricity is the best remedy we have in the treatment of these troubles, and one advantage is that it can be used in connection with any other method of treatment. The galvanic current should be used, the positive pole fitted with a cup or large sponge electrode applied over the enlargement and the negative pole over the abdomen or along the upper part of the spermatic cord, using from six to ten milliamperes for five to ten minutes at each treatment, which should be given at least once daily until relieved, using a suspensory bandage to support the testicle. This method of treatment is painless and that which pleases the patient best because he is not obliged to leave his business, and I have seldom found it necessary to order the patient to his bed or room. The trouble is generally relieved in from three to five days, and I have not had suppuration in any case of orchitis or epididymitis treated by electricity. Electricity, although most useful in acute and simple chronic cases, is very beneficial in enlargements caused by

*Read before the Ohio State Medical Society, May 5, 1892.

syphilitic and strumous conditions, but constitutional treatment is, of course, necessary. The application of cold is very useful in most cases. Orchitis due to metastasis is best treated by hot fomentations, in old and feeble subjects, when the circulation is poor, hot applications should be used in preference to cold. Cold can be supplied by the ice bag, Leiter's coils, cloths dipped in ice water, or cold evaporating lotions. To get the best results, cold should be applied as early in the disease as possible. In cases where there exists great pain, swelling or tension, local blood-letting or scarification may be resorted to. Painting with a strong solution of nitrate of silver (90 grs. to the ounce.) If there is fluid in the cavity of the tunica vaginalis a small trocar can be used to allow the fluid to escape. Pressure by elastic bag or stopping with plaster sometimes gives relief, but it is very troublesome, annoying and of doubtful utility. A treatment for epididymitis which has proven sucessful in my hands, although I have used it only a limited number of times, was given in a paper, read by Dr. G. E. Brewer before the American Association of Andrology and Syphilis, upon the treatment of epididymitis, and published in *The Philadelphia Medical News*, Oct. 1891. He called attention to this method of treatment that he had found very useful in both acute and chronic cases of this disease. The inflamed organ is covered with a thick layer of cotton wool which is surrounded by a layer of rubber tissue, extending beyond the wool to the healthy skin of the scrotum, a gauze bandage is next firmly applied and the whole is kept in place and supported by a suspensory bandage. It relieved the pain promptly and has a marked influence in promoting the rapid dissipation of the inflammatory induration.

In syphilitic orchitis specific constitutional treatment should be given in connection with local treatment. In malarial subjects quinine should be administered. Rheumatic patients should be given the salicylate of soda in ten grain doses every four hours. The diet should be light, principally milk, and animal food should be avoided. Tonics and alteratives should be used in the later stages of the disease and with hygienic measures be of assistance in completing the cure.

TREATMENT OF PNEUMONIA WITH REPORT OF CASES.*

By H. PERDUE, M. D.,

BARNESVILLE, GA.

Pneumonia holds a high position among the fatal diseases of the human race. Its victims yearly darken the plane of life from the palatial residence to poverty's hut. It claims a mighty host in the army of the dead.

While its mortality ranges from 3 to 35 per cent., its average under all circumstances, according to statistics is 20 per cent. or one out of every five. This stamps it as a fearful disease, and should claim our most serious attention and study. Human life is a precious gift from the hands of the Almighty, and it is an imperative duty to prolong it, if possible, to the extreme limit of old age.

Passing by the ætiology, pathology and diagnosis of this disease in its various forms, which being in recent works and accessible to all physicians, I shall devote my time in as concise a form as possible to the most successful methods of treatment, especially in my hands.

I shall consider principally acute croupous or lobar pneumonia. Taking as a definition of this disease that given by Dr. A. L. Loomis in his work on "Practical Medicine," viz., that it "is an acute general disease, characterized by an inflammation of the vesicular structures of the lungs with an exudation in the alveoli, which renders them impermeable to air," I shall proceed to give some of the points of treatment.

In the congestive stage, which lasts from one to three days, the patient is generally very restless, with high pyrexia, a sharp, stabbing pain beneath the nipple of the affected side, except in central pneumonia. Pleurisy, which gives so much pain, is said to be present in about 85 per cent. of all cases. In the beginning nausea and vomiting occur in about ¾ of the cases.

The first step to be taken is to relieve these distressing symptoms. Some give morphine hypodermically before the exudative process is completed. This will generally give quick relief, the thing so much desired by the patient, but I gener-

*Read before the Ga. State Medical Association, April 21, 1892.

ally prefer phenacetine, as some people do not bear opiates well. It reduces the fever, produces sweating, and gives ease. It is, in my opinion, *the* remedy *par excellence* at this period. I give it in nearly all cases, except the very old, the very young, and the very feeble, always giving alcoholics with it. I have many a time with it had my patients resting quietly and asleep 20 to 30 minutes. Five grains is the average dose for adults; about four hours apart. In a very few cases six grains will be required, and occasionally four grains will prove to be enough. The second dose may have to be given in two or three hours. The guide for diminishing or increasing the dose is the reduction of temperature produced. Sleeping and sweating are the conditions desired. I once gave 7½ to 8 grains of this medicine at a dose, but am now satisfied that five grains with whiskey should be the average dose. Sometimes it is more effective, as well as satisfactory, to give a smaller dose, and at shorter intervals. Some use cold applications to reduce the fever and give ease. Believing that the inconvenience, exposure and depressing effects are too great, I have never tried it. American practitioners are generally against it.

Some give large doses of quinine to reduce the fever. I have tried it to some extent, but like my present method better.

As soon as located some counter-irritant or soothing application should envelop the affected side, and, if the inflammation is in both lungs, the whole chest should be encased. That application may be a hot poultice, spongio-piline or cotton-batting covered with oil silk, a flannel cloth saturated with spirits of turpentine, or a mustard plaster. These should be renewed from time to time.

After some rest has been obtained, if the patient has not already been purged, it is well to give a dose of calomel. Sometimes we find a patient in great peril from venous engorgement and exhaustion of the right heart in its efforts to propel the venous blood through the capillaries of the lungs.

Formerly, to relieve this distressing symptom, venesection was practised by some, removing a portion of the venous blood; but that has been abandoned, on account of its depressing effect.

The effect of the nitrites in dilating the arterioles meets the urgent demand. Nitro-glycerine especially fulfills the indication. It is a valuable fact that it is as quickly absorbed through the stomach as when given hypodermically. It does its work quickly. On wings of mercy it flies to the rescue of the beleaguered one, unlocks the pent-up channels, and permits the waste product of the venous blood to become purified in the lungs, and the pure life-giving liquid to go on in its mission of love. It should be given in doses of $\frac{1}{100}$ gr., and be repeated in twenty or thirty minutes, if necessary, and afterwards every two or three hours as long as needed.

I always give strychnia in $\frac{1}{30}$ gr. dose, and atropia in $\frac{1}{100}$ gr. dose in this condition at the same time. They are heart and respiratory stimulants, and should be continued about four hours apart until this condition is well relieved. The strychnia, generally, should be continued through the whole disease. It strengthens and sustains the tired and flagging heart until recuperating nature comes to the rescue.

I have used, in nearly all my cases of lobar pneumonia, this season, the peroxide of hydrogen, and with good effect, I am sure. It was given for its germicidal properties, the oxygen it furnished the patients, exhilarating and strengthening them. The most remarkable therapeutic effects of this remedy in this disease that I have seen is from Dr. J. L. Green of Colorado. It is to be found in the "*Medical Record*," of New York, Feb. 6th, 1892. All of his uncomplicated cases, which were more than 150, got well. I have been giving one teaspoonful of Marchand's preparation in an ounce or two of water every ½ hour or hour. When the patient is evidently better, to prevent worrying him too much, it was given further apart. If it nauseates, and sometimes it does, the quantity should be diminished. I feel confident it has saved valuable lives. Any other good preparations of the peroxide, no doubt, would do the same.

Throughout the stages of congestion and consolidation, phenacetine in 5 gr. doses should be given in connection with whiskey, or milk punch every four hours, unless the temperature should get below 103° F. Midway between I generally give carbonate or muriate of ammo. with prun. virg. and syr. senega. In all bad cases, it is good policy to continue the peroxide about two hours apart. It hastens the crisis.

If the patient is disposed to be very

restless, and the phenacetine does not keep him quiet, I sometimes give the spts. eth. co. in teaspoonful doses. If it becomes very necessary that he should have something else to produce sleep, chloral in 8 to 12 gr. doses is an excellent remedy. If he has not had whiskey sufficiently, it should precede the chloral to prevent its depressing effects.

The patient should be kept in bed and not disturbed by conversation in the room. He should have rest, to conserve the power of nature. Good nursing is a very important part in the management of pneumonia patients.

A nutritious liquid diet, such as sweet milk, beef tea and palatable broths should be given. Sometimes the nausea is so great that patients will not readily take the diet named above. I have found Reed & Carnrick's Kumysgen, claimed to be a product of pure sweet milk, to be well borne and to sustain the patient.

The room of the patient should have fresh air throughout the whole treatment, and should be kept at a temperature of 65° to 70° F. In convalescence, stimulating expectorants and tonics are indicated.

In catarrhal pneumonia, the supporting treatment should be given from the beginning. Liquid diet, principally, should be given frequently, as the patient will not generally take much at a time. Patients should take stimulants from the beginning, and continue them throughout the treatment. I generally give carb. or muriate of ammonia during the entire treatment. Quinine is a very valuable remedy in reducing the temperature, and as an aid to resolution.

Mild mustard poultices or plasters to the chest are very valuable; also flannel cloths or jackets saturated with turpentine, diluted with oil if the patient is a child.

Great care should be exercised in convalescence to prevent a relapse or second attack.

REPORT OF CASES.

Before I begin this report I wish to state that my partner, Dr. M. A. Clark, and I visited all of these cases, sometimes together and sometimes separately, and were in perfect accord in their management.

Since the first of January we have had besides several of the lobular variety, fifteen cases of the lobar. Three of the lobar class had one lobe of the lungs affected, four had two, seven had three, and one had four. This shows an unusual *pro rata* number of the lobes attacked, yet we have not lost a *single* case. To prevent the lengthening out of this paper I will report only two cases.

CASE I. January 24th. J. C. B., male, white, age 75, had bronchitis for 20 years, had *la grippe* recently, and was just beginning to sit up from it. Had a chill night before. Was called at 3 P. M. Could not take his temperature on account of extreme nervousness. Inspection showed diminished breathing on right side, and increased on left. Palpation, increased vocal fremitus on right side. Percussion, beginning dullness over lowest lobe of right lung. Auscultation, numerous crepitant râles over middle right lobe. Pulse, 120; respiration, 38. Put him on phenacetine grs. 5, every 4 hours, with whiskey and milk; also ammonia carb. grs. 5, syr., synegæ m, 10, syr. prun. virg., ℥ss. aquae qs. ad., ℥i. To be taken in water between doses of the other medicine. 8 P. M. dullness over middle and lowest lobes of right lung, bronchophony, crepitant râles over left lower lobes showing very rapid spread of trouble. Patient unconscious and very restless. Had the lungs completely enveloped in turpentine chloths. On account of extreme restlessness, added morph. sul., ¼ gr. to each dose of cough mixture.

January 25th, 8 A. M. Right, middle and lowest lobes solidified, and upper lobe of same side evidently involved. Left lower lobe solidified. Pulse, 140. Pespiration, 48. Had a bad night, but somewhat more quiet this morning. Continued former treatment except stopped phenacetine. Prescribed Marchand's peroxide of hydrogen, one teaspoonful in water every ½ hour or hour between doses of other medicines. Three P. M. Slightly more quiet. Eight P. M. Resting more quietly. Not so hot. Unconscious. Stopped morphine.

January 26th, 8 A. M. Spent a bad night. Occasional muttering, very restless, pulse and respiration very rapid. Increased the milk punch. Put him on atropia sul. gr. $\frac{1}{100}$ and strychnia, $\frac{1}{30}$ every 4 hours. Seven P. M. Very restless, low muttering delirium, carphologia, subsultus tendinum, sordes, pulse very rapid and respiration labored, lips livid. Gave cal-

omel, grs. 30, for its sedative effect. Returned in 2 hours, found him sleeping quietly, but heart labored and respiration difficult. On awaking he was given nitro-glycerine, gr. $\frac{1}{100}$, and repeated in ½ hour, and after that 4 hours apart. Continued other medicines.

January 27th, 8 P. M. More quiet. Left off nitro-glycerine. Continued other treatment. Besides milk punch, gave beef peptonoids. Eight P. M. More restless. respiration labored, venous engorgement. Put him on nitro-glycerine again. Reduced atropia to $\frac{1}{150}$ gr.

January 28th, 8 A. M.—Rested better during the night. Continued same treatment. 7 P. M.—Rested much better during the day. Stopped nitro-glycerine.

January 29th, 8 A. M.—Death seemed imminent from exhaustion. Pushed nourishment and whiskey to the exclusion of medicines. 7 P. M.—More quiet every way.

January 30th, 8 A. M.—Rested tolerably well during the night. Dropped the atropia, but continued the strychnia, the ammonia mixture, and peroxide of hydrogen as regularly as could without disturbing him too much. 7 P. M.—Better.

January 31st, 8 A. M.—Very much better. Continued to visit him until March 9th, when he was dismissed as safe after visiting him seventeen days.

Case II.—Harry A., male, white, age 17, family history good, previous health good. Had *la grippe* with acute gastritis just preceding this attack.

February 6th, 4 P. M.—Found lowest and middle lobes of right lung involved. Temperature 105° F. Gave phenacetine, grs. five, every four hours to reduce fever. Patient being very nervous and restless, gave chloral hydrate, grs. 7½, to be repeated every two to four hours as needed to make rest. Gave Mallinkrot's peroxide of hydrogen, ℥ss in water every one or two hours. Had whole chest completely enveloped in turpentine cloths.

February 7th, 9 A. M.—Temperature 104.5° F. Respiration 28. Pulse 120. Still restless. Continued phenacetine. Gave ammon. carb., grs. v., syr. senegæ, m x., syr. prun. virg., aquæ aa℥ss every four hours. Milk punch every four hours, following each dose of phenacetine. Continued peroxide. 2 P. M.—Temperature 105° F., though we had continued phenacetine, which produced profuse sweating; changed to 3 grs. every three hours. Continued ammon. mixture. Left off chloral as he was resting better.

February 8th, 8 A. M.—Temperature 103.5° F. Respiration 28. Pulse 120. Two lowest lobes of right lung completely consolidated. Crepitant râles in upper left lobe. Continued same treatment. Sweating not quite so profuse as before, but still too great. Gave atropia sul. gr. $\frac{1}{100}$ every four hours to check excessive sweating. 3 P. M.—Temperature 104.5° F. Upper left lobe in second stage. Pulse weak and rapid, and respiration labored. Sweating not so great. Stopped atropia separately, and gave in combination atropia sul., gr. $\frac{1}{150}$, and strychnia, gr. $\frac{1}{60}$ every four hours. Left off peroxide during night, with instructions to begin again in the morning.

February 9th.—Temperature 103.5° F. Continued treatment. 3 P. M.—Temperature 103.5° F. Resting quietly; respiration and pulse showing some improvement. Left off peroxide after bedtime, so as not to disturb sleep.

February 10th, 8 A. M.—Temperature 102° F. Left off strychnia and atropia, but continued ammonia, whiskey and peroxide. Left off phenacetine, as temperature was below 103° F. 3 P. M.—Temperature 102.5° F. Resolution beginning in lowest right lobe.

February 11th, 8 A. M.—Temperature 101.5°. Better every way. 3 P. M.—Temperature 102°. Continued ammonia, milk punch and peroxide.

February 12th, 8 A. M.—Temperature 99°. General resolution over whole of affected area. Continued treatment.

February 13th.—Temperature normal. Continued to visit him till February 15th, when he was dismissed as safe after visiting him 10 days.

PREVENTION OF COCAINE POISONING.

Smith recommends that patients be prepared by giving them a drop of one per cent. alcoholic solution of trinitrine a minute before administering the cocaine, repeating the dose at intervals if the pulse be not affected and no pain of fulness in the temporal region be felt. The trinitrine acts almost as rapidly and continues to affect the vaso-dilators for upwards of half an hour longer than nitrite of amyl.

Society Reports.

THE MEDICO-CHIRURGICAL SOCIETY, OF LOUISVILLE.

Stated Meeting May 13, 1892.

DR. WM. CHEATHAM, President, in the Chair.

SUPRA-PUBIC CYSTOTOMY FOR ENLARGED PROSTATE.

DR. A. M. VANCE: I will report a case of considerable interest. About five weeks ago I was called by Dr. Bates to see a patient seventy-eight years of age, who had been for three years subject to bladder trouble. He had occasional attacks of retention of the urine, due to enlarged prostate. The day I saw the case, the patient had ridden fifteen miles, was suffering greatly and could not empty his bladder. Previous to my seeing him, several physicians had failed to relieve by catheterization I at once aspirated the bladder, and, afterward, repeated the operation fifteen times. Then a supra-pubic cystotomy was done making the incision through the site of these sixteen aspirations. The bladder was emptied and washed out. Case progressed nicely for seven days, wound did well, had primary union. The patient was allowed to walk about. On the eighth day, however, he died suddenly, probably from heart clot. No post-mortem examination was made. There was some induration around the site of the punctures. No urine passed through the urethra after the operation.

DR. A. M. CARTLEDGE: The case related by Dr. Vance gives us something new to talk about. The treatment of enlarged prostate is very varied. I believe that we have especially struck a new era for dealing with enlarged prostate in old people. The question to be decided is when, and in what cases, are radical measures justifiable. It has been the rule in my practice, after failing to introduce a catheter, to aspirate, then give cathartics, quinine etc. together with hot applications. This plan usually gives relief and the bladder for some time afterward can be emptied by catheter. The attacks of retention, however, will generally recur, and the patient dies usually in the third attack. I think it time to formulate this rule: If, after an hour or two, the catheter cannot be passed, then do a supra-pubic cystotomy at once. In my opinion the operation is often put off too long in these cases.

DR. E. R. PALMER: Dr. Watson has written the best article on enlarged prostate that I have ever read. In these cases there are so many collateral troubles that the patients are usually ready to die, and, if an operation is done, the knife gets the credit of killing them. There are nearly always degenerate changes in the mucous membrane of the bladder, ureter, pelvis of the kidney, and in the structure of the kidney itself, consequently, an operation is badly borne. I like the perineal operation in middle life; in old men, the operation ought to be the supra-pubic. The operation ought to be regarded as the first, rather than the last resort.

DR. W. O. ROBERTS: I strongly advise the supra-pubic operation to relieve retention of the urine from enlarged prostate. The retention is apt to recur often, and each time damages the case. The operation is simple, and when done early gives excellent results. Dr. Davis read a paper before the Southern Surgical Association in which he stated that it was his rule, when called to a case of retention due to enlarged prostate, to operate at once. Dr. Davis first passed a large trocar, then withdraws and inserts a catheter. Later on he uses a tube, the outer end of which can be closed by a cork. I have operated once according to the plan of Dr. Davis, using a large trocar and then inserting a No. 12 catheter. I think, however, there is always danger of introducing germs when catheters are used.

DR. WM. BAILEY: I have recently seen two cases of retention of urine, both of which were relieved by the hot bath. In one case, where the patient was under forty-years of age, the tumor extended above the umbilicus. There was a history of gonorrhœa. I passed a soft catheter and only removed one drachm of urine. I thought I had not reached the bladder, but only a little sac in the urethra with the catheter. I then placed the patient in a hot bath, and the tumor disappeared without the patient being conscious that he had passed any urine. I believe that it is oftentimes better to temporize than to subject an old man to a capital operation. I think, however, that cystotomy is a less evil than repeated catheterization.

DR. J. W. IRWIN: I commend all that

Dr. Bailey has said on this subject. I have never seen a case of retention in an old man in which I have not been able to enter the bladder without restorting to a cutting operation. In case an operation is imperative, I prefer the operation through the perineum, rather than the supra-pubic, because it establishes drainage. In these cases there is always more or less muco-pus, and this cannot be emptied through the supra-pubic opening. I believe that I have prolonged the life of many patients by not performing any surgical operation.

OPERATIONS IN NEW YORK HOSPITALS.

DR. W. O. ROBERTS: Having just returned from New York, I have been requested by our Honorable President, and several Fellows of the Society, to give a short resumé of my trip, and of the operations I witnessed in the East.

I saw Dr. Polk, at Bellevue Hospital, operate for fibroid of the uterus. He did a hysterectomy according to Freund's method. Used drainage tube and packed the vagina with iodofom gauze. The patient's temperature was 100° on second day, afterwards was normal. Dr. Polk does this operation in all cases of fibroid tumors of the uterus, when they give rise to symptoms. In case of chronic endometritis, Dr. Polk first dilates the cervical canal by Goodell's dilator, then scrapes the cavity of the body with a sharp curette, after which he washes out the cavity and packs it through a speculum with iodofom gauze; he also plugs the vagina with the same material. This vaginal plug is removed on third day and the canal douched. The uterine plug is allowed to remain one week. All the cases got well under this treatment.

At the Hospital for the Ruptured and Crippled, I saw Dr. Gibney do a number of tenotomies for deformities of the neck, foot and hand; he employs the subcutaneous method. Many surgeons in New York, however, do the open operation, even when the tendo-achillis has to be cut. Dr. Abbe employs the open method. Saw Dr. Abbe tie a fractured patella with subcutaneous ligature, after which the leg was put in fixed dressing.

At Presbyterian Hospital, Whitehead's operation, also an operation for hare-lip, were witnessed, Dr. McCosh being the operator.

Saw Dr. McBurnie do an amputation: Case was a young woman with an enlarged leg from middle of thigh to toes; marked hyperæsthesia in the limbs. Diagnosis not made. A circular amputation of thigh was done, hæmorrhage in the case controlled by digital compression of femoral artery. The amount of blood lost was very small.

In skin grafting operations, Dr. McBurnie frequently uses grafts four inches long. He first places, the grafts in a salt solution (.6 of 1 per cent.), and, after applying them to the wound, covers them with sterilized gauze which has been previously soaked in the same solution. Around this is put absorbent cotton. The dressing is changed every forty-eight hours, except the rubber tissue which covers the drafts, this is allowed to remain seven days.

Saw Dr. McBurnie remove a portion of a very large thyroid gland, which was interfering with the respiratory act. A large number of vessels were ligatured before cutting. The enlargement proved to be cystic.

While in Philadelphia, visited Dr. Pierce and Dr. Goodell and witnessed several of their operations.

REMOVAL OF ENLARGED INGUINAL GLAND.

DR. W. L. RODMAN:—The specimen I have to exhibit is an enlarged gland removed from the inguinal region. The patient was a young man eighteen years of age, and the tumor before removal looked to be as large as a duck's egg. There was no suppuration. I removed all of the superficial inguinal glands, and the largest (which you see here) was close to the femoral artery. In dissecting it I used my fingers very largely. Some of the glands were almost ready to break down. I would advise this operation as the quickest way to cure these cases.

DR. T. L. MCDERMOTT:—I have seen three cases of bubo of non-venereal origin during the last ten days.

DR. E. R. PALMER:—I regard the surgery of bubo faulty, and think that the whole literature concerning its surgical treatment ought to be re-written. I agree with Dr. Rodman in advising enucleation. I strongly condemn the modern practice of removing the roof of the bubo, curetting, packing and leaving it to granulate. This always leaves a large unsightly scar. I always urge enucleation in non-venereal enlarged inguinal glands, and, believe, that it shortens what would otherwise be a tedious recovery.

DR. H. A. COTTELL:—Two or three years ago, I published from advance sheets, an article of some English surgeon, in which he advised the early removal of these glands, especially those about the neck.

I believe, however, that enlarged lymphatics, non-venereal in origin, do not require surgical interference, but can be made to resolve under alteratives and appropriate local applications.

PERIARTICULAR INJECTIONS OF CHLORIDE OF ZINC IN RECURRENT DISLOCATION OF THE SHOULDER.

Dubrueil (*Sem. Méd.* February 27th, 1892) relates the case of a muscular man, aged 40, who was subject to frequent dislocation of the shoulder, which made it difficult for him to earn his living. The accident occured five times in two and a half months, owing to such apparently inadequate causes as throwing a stone, sudden abduction of the arm, etc. It occurred to Dubrueil to try the effect of chloride of zinc injections, such as Lannelongue has found so successful in tuberculous inflammations of joints. (See *British Medical Journal*, 1891, vol. ii, p. 86). His idea was that the chloride of zinc would have a "sclerogenic" effect on the tissues about the shoulder-joint, thickening, tightening, and strengthening the capsule. Between January 5th and 16th he made six injections of 2 drops of a 1 in 10 solution of chloride of zinc at various points of the superior and anterior part of the shoulder underneath the acromion. Strict antiseptic precautions were taken both before and after the injection, and the point of the syringe was thrust into the tissues deep enough for the chloride of zinc solution to come into contact with the capsule. The injections caused only a trifling amount of pain, and were never followed by reaction. After the sixth injection the patient was directed to assist in the work of the ward, and in particular not to spare his shoulder. He was also made to perform violent movements of abduction and circumduction of the point in presence of the surgeon, but no luxation took place, and he was discharged on January 28th, with his shoulder apparently perfectly sound. Dubrueil thinks it probable that the cure will be permanent, and recommends the method as, at any rate, easy and harmless.—*Brit. Med. Jour.*

Selected Formulæ.

OTALGIA.

Dr. A. Dixon (*The Prescription*, No. 1, 1892) employs the following:

℞ Cocain. muriat. (4 per cent. sol.).....fl. 3j.

Drop three or four drops into the patient's ear. Repeat in fifteen minutes if not better.

COUGH OF PHTHISIS.

Professor Pepper states that inhalations are to be preferred in the paroxysms of cough. He has found the following formula of service:

℞ Creasoti.....3j.
Tr. iodi.....3iij.
Chloroform.....3ij.
Sp. vini rect.....q. s. ad. 3j.
M. Sig.—Inhale 10 drops.

Carbolic acid, in somewhat smaller dose, or thymol may be substituted for the creasote, and tincture of conium for the chloroform.

PRURITIS.

℞ Menthol..... 4 grms.
Alcohol..... 30 grms.
Water..... 60 grms.
Acetic acid.....180 grms.
M. Sig.—Apply with a sponge.

—*Le Progrès Médical.*

DYSPNŒA OF HEART DISEASE.

Little, in the *Birmingham Medical Review*, states that he has employed for many years the following solution in the hypodermic treatment of the dyspnœa of cardiac disease:

℞ Sulphate of morphine.....gr. iv.
Hydrate of chloral.....gr. ii.
Atropine sulphate.....1-10 gr.
Camphor water, enough to make 4 drachms.
Sig.—Fifteen minims at a dose.

The chloral is added merely to make the solution keep. It renders the injection slightly painful, and may be left out if the liquid is to be used within two or three weeks of the time that it is prepared.

LEMON TONIC (CHARITY HOSPITAL).

℞ Cinchonine sulphate.....30 grains.
Citric acid.....30 grains.
Tinct. chlor. iron.....30 minims.
Syrup.....1½ fluid ounces.
Water to make.....4 fluid ounces.—M.
Dose.—A teaspoonful.

INJECTION OF AMMONIA-CITRATE OF IRON IN CHLOROSIS.

Dr. Alvazzi, of Turin, has successfully used the following formula:

℞ Ammonio-citrate of iron.....1.20 grms.
Distilled water.
Laurel water.....ää 5.00 grms.—M.

The Pravaz syringe was used, the dose in the beginning being 2 centigrammes of the salt, once daily, gradually increased to 12 centigrammes.

ANTISEPTIC MOUTH WASH.

℞ Acidi thymici..... 0.25 grams.
Acidi benzoici..... 3. "
Tincturæ Eucalypti..... 15. "
Spiritus vini rectificati.....100. "
Essentiæ menthæ piperitæ..... 0.75. "
M. Sig.—Drop enough into a glass of water to cause turbidity, and rinse the mouth morning and night.

—*Muller.*

A REFRESHING BEVERAGE.

Bamberger (*Formulaire de la Fac. de Méd. de Vienne*) suggests the following potion to quench the thirst of pneumonia patients:

℞ 1. Acidi phosphorici..... 8 grammes (3ij).
Syrupi rubi idæi..... 90 grammes (3iij).
M. Sig.—To be taken in water.

℞ 2. Potassii bitartratis..... 8 grammes (3ij).
Syrupi rubi idæi..... 40 grammes (3x).
Aquæ.....400 grammes (3xiiss).
M. Sig.—Use as a refreshing drink.

—*Le Progrès Médical*, February 6, 1892, p. 109.

DIPHTHERIA.

Dr. T. M. Culver (*Med. Free Press*, 1891, ix., 211.) says the patient should be completely isolated, the room maintained at a temperature of 70°, and kept moist with steam. Bowels kept open and chlorate of potash water given as a drink.

Internally,

℞ Hydrarg. bichlor.....gr. j.
Ess. pepsin.....3ss.
Elix. simpl., q. s. ad.....3jv.
M. Sig.—Teaspoonful every two hours.

Locally,

℞ Papoid.....3j.
Sal. lister.....3ij.
M. Sig.—Blow x grs. in throat every two hours.

Out of a record of forty cases treated as above, thirty-five recovered. In two cases the larynx was so seriously involved that intubation was done. Of these cases, one recovered and the other died of heart failure.

DIARRHŒA.

℞ Salol.....3ij.
Bismuthi subnitratis.....3iv.
Mist. cretæ.....q. s. ad. 3iij.
M. Sig.—One teaspoonful every two hours.

OCCUPATION FOR THE FEEBLE-MINDED.

From time to time we are reminded by by its effects upon social or political conditions that the thinking power of Birmingham is not bounded in its applications even by the wide circle of its varied industries. Art and science have been appreciably indebted to its influence. It is, however, especially in the guidance and reform of civic and social usages that we are accostomed to trace the effects of this healthily active leauen. By way of illustrations, we may mention a recent project which owes its rise to the kind originality of a ladies' committee. There exists in the hardware capital, as in order cities, a residuum of mentally weak but not incapable persons. Overmatched intellectually by the average man or woman, they have no definite position or sphere of usefulness among their neighbors, and are consequently as a rule dependent either on friendly maintenance or on parish relief. The committee already mentioned has taken account of these poor people, or more strictly, of the women among them, and has organised for them a system of profitable employment. This consists in the establishment of a laundry with adjacent cottage homes. The household and working expenses of the institution are to be defrayed partly by the earnings of the inmates and partly by subscriptions paid by their relatives or by parochial guardians. In this way their intellectual talent, however meagre, will be utilised, and it is at least probable that an effectual check will be placed upon the reproduction by such persons of a progeny as lacking in parental care as in mental capacity. There is also a very fair prospects that the mere process of employment will do something to awaken and strengthen the dull faculties of these semi-imbeciles. Every true friend of his species will therefore wish well to the Birmingham expermiment, which might even be extended to meet the case of half-witted men, and which, if successful, will certainly not fail to be repeated in the social usage of other communities.—*Lancet.*

THE

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Leading Articles.

THE THERAPY AND ÆTIOLOGY OF ACUTE DIGESTIVE DISTURBANCES OF CHILDHOOD.

When the still enormous death-rate among children and infants is contemplated, and at the same time it is known that a large number of these deaths are directly or indirectly due to some acute digestive disturbance, then anything that tends to throw any light upon the subject cannot fail to awaken the keen interest of every practitioner. True, our increased knowledge of the hygiene of childhood, and especially of infant dietetics, has materially increased the chances of life of such children as come under our care, yet even our present therapeutic means are far from being all that could be desired, and the experiences of those who have made this subject one of special study must be of immediate value.

Dr. Sonnenberger, of Worms, in an article on acute digestive disturbances of childhood, especially cholera infantum, which appeared in a recent number of the *Allegemeine Medicinische Central-Zeitung*, speaks extensively of his experiences with resorcin in these and kindred troubles. It has been some time since Dr. Frühwald called the attention of German physicians to the value of this drug, laying special stress upon its happy action in those digestive disturbances of childhood accompanied with vomiting, and especially on its value in cholera infantum. Since that time, which is now several years ago, Dr. Sonnenberger has been constantly using the drug in these ailments in the St. Anna's Children's Hospital of Vienna, and in the majority of cases has had occasion to be more than satisfied with its prompt and efficient action. Especially in cases of obstinate vomiting can one rely upon its efficiency. Nor has Dr. Sonnenberger been alone in his high opinion of the value of

this drug, for Dr. Menche, a German pædiatrist of note, has recently contributed an article to the *Centralblatt fur Klin. Medicin*, entitled "Nine Year's Experience with Resorcin as an Internal Medicament," which is an encomium of the therapeutic value of this agent.

Until recently the therapy of acute digestive derangements of children has been rather uncertain, and guided more by individual than general experience. The use of calomel in cholera infantum is certainly of great value, but the most threatening and dangerous symptom—the vomiting—is not always checked by it, and for this very symptom we have a most prompt and efficacious remedy in resorcin. In doses varying from 0.15 to 0.20 gramme daily, resorcin never gives rise to any symptoms of poisoning or intolerance. Upon the diarrhœa it seems to exert but little influence, so that in the therapy of cholera infantum an astringent should also be administered.

Considering that resorcin has such valuable properties it is rather surprising that its use in this class of cases is almost wholly unknown. It is equally surprising that the majority of writers on pædiatrics have completely overlooked the drug, although this may be explained by the fact that as in large doses it is apt to cause toxic symptoms writers have hesitated to recommend it. Among authors who refer to it are—Bredent (*Lehrbuch für Kinderkrankheiten*); Epstein, in a recent work (*Uber das Wesen und Behandlung der Cholera Infantum*, who discards its use altogether, as being a dangerous drug in infancy; Baginsky, in the first edition of his well-known work, (*Lehrbuch fur Kinderkrankheiten*), who speaks of its efficacy, yet refers with caution to its powerful toxic properties, but in the third edition of the same work he makes no reference to the drug whatever.

These fears of a possible poisoning, we are told by Menche, are without foundation when the drug's use is confined to the daily dose of 0.1 to 0.12 gramme during the first months and 0.15 to 0.2 gramme for older children. Similar doses are recommended by Seifert in his work on Children's Diseases, and by H. Guttmann in his book on the same subject. Sonneberger, Menche, Fruhard, and Concetti (who used it even in larger doses in whooping-cough), who constitute the authorities who have used the drug and given it the most careful study, have never observed the slightest unpleasant symptoms accompanying or following its use when employed in the above named doses. The danger of possible poisoning is greatly lessened by the use of a pure drug.

It has been recently conceded that opium should never be given alone in acute digestive disturbances of children, but always in conjunction with some disinfectant. Moreover, the use of this drug in infants should be restricted to very small doses, never exceeding one or two drops of the tincture per diem. Many of the most recent writers discard opium entirely. Liebermeister, for instance, asserts that in children under one year of age opium should never be used, claiming that even when given in minimum doses so small that no beneficial action can be obtained, there is possible danger. He substitutes the tincture of nux vomica, and in cases of cholera infantum in infants about six months old uses the following formula:

℞ Sodii bicarb. .....2 grams.
Tinct. nucis vomica, ...gtt V
Aquæ fœniculi.....30 grams
Sacch. albæ..... .....5 grams.
M. Sig. One half teaspoonful every half hour

The use of opium is attended with far greater danger in children than in adults, and symptoms of poisoning and collapse are only too easily produced, especially as in these cases of digestive derangement there is a tendency to collapse. Sonnenberger reports a case of severe opium poisoning, which fortunately terminated favorably, in a child one and a half years

old, that had been given seven drops in the course of a day and a half of the simple tincture of opium. If opium be given at all it should be only in those cases in which there is no tendency to collapse. Seifert, the eminent German pædiatrist, gives the following table of doses:

For children up to one year of age ½ to 1 drop of the simple tincture of opium daily; from one to two years of age, 1 to 2 drops, always in combination.

The formula in which Sonnenberger has so successfully employed resorcin is as follows:

℞ Resorcin pur..... 0.1-0.25 gram.
Infus. chamom.....70.0 grams.
Tr. opii camph.....gtt. 1 to 11.
Syr. aurant. cort.....30.0 grams.
M. Sig.—Half a teaspoonful every one or two hours.

The opium may be replaced by tincture of rhatany or tincture of cascarilla. Excellent results can confidently be expected from the use of this formula.

Finally, regarding the ætiology of cholera infantum, Sonnenberger, Meinert and other recent investigators of the subject do not consider it a specific disease, rather a symptomatic complex which may be regarded as acute gastro-enteritis. Ætiologically, the disease may be the result of varied factors. In one case it may truly be due to the action of a specific germ; in another the result of poisoning by means of chemical compounds, or poison in food or milk, in the latter case the poison may be some vegetable alkaloid in the milk. This much mooted question is one open for discussion, but surely these recent contributions are of great value.

Book Reviews.

A TREATISE ON DISEASES OF THE NOSE AND ITS ACCESSORY CAVITIES. By Greville MacDonald, M. D. (London), Physician to the Hospital for Diseases of the Throat. Second edition. London and New York: MacMillan & Co., 1892. Price, $2.50.

The perusal of the first chapter, if no more, of this work will amply repay even the most preoccupied of the profession. The masterly manner in which the functions of the nose are discussed and the lucid descriptions of the methods of determining the conditions present, lead one to marvel that so many special books on the nose should have been issued.

The author presents his subject in an interesting and pleasing manner, and his deductions are logical and deliberate; his expressions are frank and without egotism; and his composition is so enticing that one finds himself in the midst of the work and in possession of accurate and carefully sifted information, without effort.

The views on vexed questions of function, pathology and ætiology are set forth with great fairness, and the conclusions are the natural outcome of the author's logical mind and scrupulous methods. The chapter on nasal reflexes is particularly frank and modern, and the suggestion that judgment be suspended "until future and more precise observations are forthcoming" cannot fail of approval. While placing great stress on the significance of the presence of abnormal conditions in the nose, it is only in their relations to nasal breathing, and not to hastily inferred reflex bronchial conditions, that he attributes the necessity for their removal.

In discussing surgical procedures the methods are clearly and concisely set forth. While illustrations of instruments are few, they are well chosen and fairly drawn. The absence of gaudy lithographic plates is quite refreshing. In typography, marginal notes, excellent paper, perfect proofreading and full index, the work is highly commendable.

A TREATISE ON BRIGHT'S DISEASE OF THE KIDNEYS: Its Pathology, Diagnosis and Treatment; with Chapters on the Anatomy of the Kidney, Albuminuria and the Urinary Secretion. By Henry B. Millard, M. A., M.D., Fellow of the Acad. of Med. of New York, and of the American Acad. of Med., etc, etc. Third edition. New York: William Wood & Co., 1892.

This well-written treatise upon the various forms of renal disease, which collectively are classified as Bright's disease, has reached its third edition, and we note several improvements both in revision and addition. The author has not changed his views regarding the supremacy of his own test for minute quantities of albumen, and, indeed, gives much confirmatory evidence of its extreme delicacy.

A striking feature in this edition is the

change which has occurred in the author's mind concerning physiological albuminuria. After summing up the available evidence and considering carefully the result of more extended clinical observation, he has made up his mind that physiological albuminuria does not exist, and that when albumin is present in the urine it depends upon a structural lesion. This portion of the book is of great interest, and the position taken by Millard, which to us is untenable, will no doubt be widely discussed by those interested in renal medicine. The chapter on the tests for albumin in the urine has been largely rewritten, and is now quite up to date.

The book is essentially a practical one, and the repeated editions prove beyond doubt that it fills a field of usefulness. It is attractively printed and bound, and presents the most modern views concerning the important subject of Bright's disease. The portion devoted to treatment is of great interest, and is admirably arranged. Th drugs which have really been found of service have been given due prominence, while those that are of future promise have not been overlooked. As a readable and serviceable book we heartily recommend it to the profession.

Periscope.

THERAPEUTICS.

THILANINE, A LANOLINE DERIVATIVE.

Dr. Siebels (*La Semaine Medicale*, No. 57, 1891) has obtained by the action of sulphur upon lanoline a new lanoline derivative—thilanine—brown sulphurated lanoline. This substance, of which the chemical composition is still unknown, is a chemical compound and not a mechanical mixture. It contains three per cent. of sulphur. According to Dr. Saalfeld, who tried it in a large number of cutaneous diseases, it is a precious acquisition to dermato-therapy. It is entirely devoid of irritating action, and it cures such dermatoses as dry and humid eczemas, sycosis, acne rosacea, much more quickly than Hebra's salve, borated vaseline or lanoline. He regards it as specially a substitute for Hebra's salve. It has a sedative action upon pruritus.

NITRO-GLYCERINE FOR ASPHYXIA.

In a case of asphyxia from the inhalation of gas, Hoffman succeeded in relieving the symptoms by the subcutaneous administration of nitro-glycerine in doses of one hundredth of a grain. The injection was made in the precordial region, and was followed by marvelously prompt results.—*Journal American Medical Association*, December 26, 1891.

TREATMENT OF RINGWORM.

Dr. Goldsmith writes to the *British Medical Journal* that, when all other remedies had failed to effect a cure in three cases of ringworm of the scalp, in his own family, he tried Dr. Illingworth's method with prompt success. The formula for this strong blistering fluid, one application of which its originator claims will cure an ordinary case, is as follows:

℞ Hydrarg. biniodid.....3 ss.
Sol. sodii iodidi (1 in 4).....3 ss.

A small portion of this is to be diluted with three parts of water, at the time of application. It is to be painted on with a camel's hair pencil.

COFFEE AS AN ANTISEPTIC.

The experiments of Luderitz, of Vienna, tend to establish the belief in the antiseptic properties of coffee. A strong solution of coffee, for example, ended the career of a bacillus of typhoid in about twenty-four hours, the active streptococcus of erysipelas in twelve hours, while not longer than from three to four hours was sufficient to kill the malignant comma bacillus of cholera. Strong decoctions acted more quickly still; the effects, however, are stated to be due more to the products of the roasting of the coffee than to the active principle of the berry. In this connection it has been pointed out by a correspondent of the *Indian Medical Gazette* that it would be worth while to substitute coffee for tea among the cases of enteric fever in the European military hospitals in India. Coffee also might be given a trial in the treatment of typhoid fever in this country. As a beverage, doubtless, it would be appreciated by the patient, and in the light of Luderitz's researches, there is just the possibility that it might have some controlling influence over the disease.—*Medical Press.*

MEDICINE

TUBERCULOSIS OF THE TESTICLE.

Dr. Reboul, of Marseilles, treated three cases of this disease by injections of naphthol-camphor. He injected four to five drops every eight to ten days into the thickened tissues of the testicle and epididymis. Marked improvement was effected, the diseased parts becoming more indurated and contracted; and these results are more noteworthy since in two of the cases other measures continued for a long time had been unsuccessful.—*Allgem. Medicin. Central Ztg.*

A CAUSE IN THE PATHOLOGY OF THE ARREST OF GROWTH.

Fourriére (*Journ. de Mèd. de Paris*, 1892, January 4.) says: To the two recognized causes of arrest of growth, poverty, want and rachitis, should be added dyspepsia combined with dilatation of the stomach.

"The arrest of growth occurring among those suffering from dyspepsia with dilatation, probably from insufficient assimilation, constitutes a disease curable by means addressed to the treatment of the dilatation of the stomach, notably by massage of the stomach." M. Fourrière reports six cases.

DIPHTHERITIC DEGENERATION OF THE NERVES.

According to Moos (*Rev. Mens. des Mal. de l' Enf.*, September, 1891), there are two groups of changes which depend upon diphtheritic paralysis. In the first the changes affect the vascular system; in the second the nervous. The principal lesions of the vessels are thrombo-arteritis, phlebitis and hæmorrhage. The changes in the nerves are degenerative. Hæmorrhages have been observed in the intervertebral ganglia, the cord, the protuberance, the bulb, and even in the cerebrum. Most frequently there is parenchymatous neuritis of the peripheral nerves. In several cases the author has discovered micro-organisms, not only in the perineurium, but also in the nerve bundles. The paralysis may be attributed to specific organisms, or to secondary infections, caused by streptococci. The toxalbumins secreted by microbes may also be influential in the pathogenesis of the paralysis.

SURGERY.

A NEW METHOD OF SKIN-GRAFTING.

Dr. Prince A. Morrow, of New York, describes a new method of skin-grafting, the peculiarity of which consists (1) in the depth of the graft, which includes the entire thickness of the skin, and in some cases a layer of subcutaneous tissue; (2) in the method of precedure, which consists in removing a button of tissue (35 to 40 millimetres in circumference), of any required depth, by means of a round, cutting instrument, known as the Keyes cutaneous punch; and immediately inserting it in a receptacle or bed previously made by the same instrument.

In this way there is obtained perfect coaptation of graft with the base and margins of the surrounding tissues, thus insuring the most favorable conditions for immediate union of the parts. In fact, the absolute accuracy with which this may be done leaves nothing to be desired from a mechanical point of view.—*The International Journal of Surgery*, February, 1892, p. 41.

A CASE OF PRETERNATURAL ANUS; ENTERECTOMY, ENTERRORHAPHY, FOLLOWED BY IMMEDIATE RECOVERY.

Prof. Angelo Mazzucchelli (Pavia, Italy) records the case of a boy, æt 8. The preternatural anus presented itself after operation on a gangrenous loop of intestine belonging to an incarcerated inguinal hernia. The spur which separated the two intestinal ends was destroyed by means of an elastic ligature, which was left in situ for eight days. After the lapse of this period it was attempted to close the fistula, but the edges would not unite. The author, subsequently, performed in this case enterectomy and enterrorhaphy. About three centimeters were resected from each end of the intestines toward the convexity of the spur, in such a manner as to decrease towards the mesentery. Then the sutures after Czerny's method were applied. The intestines were then replaced into the abdominal cavity, the parietal peritoneum, as well as the abdomino-scrotal wound closed. The wound healed by first intention and the patient recovered quickly.—Meeting of Medico-Chirurgical Society, Pavia; *Gazzetta degli Ospitali*, No. 89, p. 708. 1890.

OBSTETRICS.

CÆSAREAN SECTION FOR ECLAMPSIA.

Swiecicki (Przeglad Lekarski, abstracted in *Repertoire Universel d' Obstetrique*, 1891) reports a case as follows: A 7-para, who for five hours had eclamptic seizures and had been comatose. There was œdema of the lungs with a scarcely countable pulse. The os was not at all dilated. Cæsarean section was done without special difficulty, the operation lasting thirty minutes. The child was asphyxiated and could not be revived. The woman's pulse, during and after the operation, improved a little, but the coma deepened, and the woman died of œdema of the lungs. The course of this case disproves Halbertsma's assertion that the operation always has a favorable influence upon the eclampsia. Here the effect was practically *nil*. In another case, quoted by Swiecicki, there were maniacal attacks after the operation. —*Univ. Med. Mag.*

LEUCEMIA AND PREGNANCY.

Laubenburg says that (*Archiv für Gynakologie*, Band xl., Heft 3, 1891).—Leucemia in women is an exceedingly rare affection, much rarer than in men (according to Birch-Hirschfeld, 32.5 per cent to 67.5 per cent). Laubenburg was able to find only three cases reported in literature. He has a case under observation, the history of which is briefly as follows: Patient 32 years old, pregnant, came to the hospital with marked symptoms of anemia; these she had had for three years and they had been the direct cause of three miscarriages. She had been married twelve years; six children four abortions. Her previous history was negative. Present illness began about seven years ago; no assignable cause. She complained of weakness, loss of appetite, indigestion, palpatation, dizziness, etc. The weakness frequently compelled her to remain in bed for from four to six weeks at a time. Of late she menstruated very irregularly, only a small quantity, and this very pale. She never had any hæmorrhages. During the past year she had a yellowish hue, lasting for a short time. For three or four years she had observed a tumor growing on the left side. An examination on admission to the hospital revealed great pallor and somewhat icteric hue, general anasarca. Uterus (fundus) three fingers below the umbilicus. The left hypochondrium filled by an enlarged spleen. The liver extended four centimetres below the free border of the ribs. Lungs normal. Heart not enlarged; systolic murmur at the apex. Pulse small and rapid (100). The jugulars showed a venous pulsation. A diagnosis of pregnancy (fifth month) was made. Examination of urine showed considerable albumin and a few granular casts. Examination of blood: Increased number of white blood corpuscles (w : r : : 1 : 10). Miscarriage on December 19th; breech presentation; amount of blood lost slight; child macerated and corresponding in size to about the twentieth week; duration of labor, twelve and a quarter hours. Three hours after labor patient's condition became very bad, and she gradually grew comatose. A difficulty in hearing was especially marked. At the expiration of forty hours, in spite of stimulation, she died of pulmonary œdema. Just before death a peculiar cadaverous odor developed (this has been noticed and described by Eichhorst, Steinberg, and Schultze). Fifteen hours after delivery the urine contained albumin and a few granular casts; in the blood the ratio of white to the red corpuscles was one to fifteen. Thirty hours after delivery there was scarcely a trace of albumin and no casts in urine; the ratio of white and red corpuscles was 1:20. No micro-organisms found in the blood. Autopsy: Substance of brain exceedingly pale. In abdomen moderate quantity of yellowish, transparent fluid. Mesenteric glands not swollen. Spleen markedly enlarged and adherent to the diaphragm. On its posterior surface a white cicatrix can be seen; this is partially calcified (rupture of spleen?). Microscopically, hyperplasia of the spleen pulp, slight increase and extension of the trabecula. Liver enlarged, yellowish-brown. Microscopically, increase of interstitial connective tissue and cellular infiltration; many liver cells atrophied; fatty degeneration. Capsule of kidneys adherent in places. Kidneys on section are pale; the right has red and yellow spots upon it. Microscopically, principal change is in the cortex; the cells of the glomeruli and canaliculi show a cloudy swelling, and in their vicinity, are lymphoid infiltrations. Left ovary atrophied; the right enlarged, containing a small cyst; alongside of this a corpus luteum verum.

Microscopically, the follicular ovarian tissue is very feebly developed; otherwise nothing pathological. Uterus well contracted; mucous membrane extremely pale. From a study of this and the other reported cases Laubenburg concludes:

1. That leucemia may at times stand in direct relation with the disturbances caused by pregnancy, labor, or the puerperium; 2, that it may be the direct cause of an abortion; 3, that it becomes more severe during pregnancy; 4, the prognosis becomes decidedly worse, even very grave, at times during pregnancy or labor; 5, the induction of premature labor is to be recommended, and that in the early months of pregnancy.

GYNECOLOGY.

WHAT CASES SHOULD BE DRAINED AFTER ABDOMINAL SECTION?

Dr. Rufus B. Hall, of Cincinnati, has drained in every case of abdominal section which he has made since 1886. The objections to the drainage-tube that have been given at various times are that it is a source of septic infection, a frequent cause of hernia, a foreign body, a cause of irritation, and not infrequently omentum becomes fastened in the perforation, preventing its easy removal. As to the first objection, the author has seen no case of sepsis developed from the use of the drainage-tube; but it is evident that, unless the utmost care is taken, such an accident might occur. The tube should be pumped out every hour or two until it is removed. In his own cases he has seen two hernias developed in the line of cicatrix, but in neither of them did the hernia occur at the point where the drainage-tube was placed. He has seen no appreciable disturbance from irritatian of the tube since he commenced using the small, perfectly smooth tube with no side perforations. The small, perforated tube of Dr. Price fulfils the requirements for abdominal drainage perfectly. If the dressing is so arranged as not to make pressure upon the outer end of the tube, no apprehension need be entertained as to it causing trouble from irritation, provided it be removed just as soon as the fluid becomes straw-colored. If one employs the old style tube, with large side perforations, there is danger of omentum becoming forced through the openings, causing difficulty in removing the tube and possibly favoring the development of hernia; but in the use of the small tube with the narrow perforations, these dangers are reduced to a minimum.—*Medic. Record.*

PEDIATRICS.

ORBITAL HÆMORRHAGE IN YOUNG CHILDREN.

Spicer (*Brit. Med. Journ.* 1891, ii., 1313.) writes—These hæmorrhages occurred beneath the periosteum, in the course of infantile scurvy, a disease generally known as scurvy rickets. The subjects were hand-reared infants, generally between six and eighteen months of age, who has been brought up mostly on "infant foods." After a period of ill-health, spontaneous hæmorrhage came on beneath the periosteum in various parts of the body, sometimes, but not always, during the course of an attack of rickets. In the orbit the hæmorrhage in two forms, either as a line of blood-staining at the orbital margin, or as a large effusion producing displacement of the eye and distension of the upper lid; the form which the hæmorrhage assumed was due to the anatomical disposition of parts in the orbit. The hæmorrhage subsided rapidly at first, but did not disappear entirely; the eye was left prominent for many months. The treatment was essentially that of scurvy; in addition to the ordinary food, juice of fresh meat, a little fruit or vegetable, cod-liver oil, or cream should be given. The slighter cases recovered rapidly; the more serious ones were slow in progress and often fatal.

HYGIENE.

DENTISTS: A NECESSITY, NOT A LUXURY.

Dentistry is undoubtedly the most useful and the most reputed of the departments of specialised surgery. The idea that the care of the teeth might safely be confided to the extractive mercies of the family medical attendant has long since been exploded, and of late years people of the middle classes of society have more and more availed themselves of the services of the skilled dentist. As a nation we are still far behind our Transatlantic cousins in the amount of attention and care bestowed on the beautification and conservation

of the teeth, but year by year the prophylactic value of the dentist's skill is becoming more widely appreciated. At the last meeting of the Board of Management it was decided to appoint a paid dentist to attend to the teeth of the children in the Hanwell Parochial Schools, and few persons will be disposed to find fault with an innovation so conducive to comfort and health. There still survives an impression that a dentist is a luxury, but it is not so long since that the importance of attending to the eyesight of school children has come to be generally recognized. The dentist will probably do more to procure relief from suffering and to promote health than even the optician, and we cannot but applaud the new departure.—*Med. Press.*

PROGRESS OF CREMATION.

Cremation appears to be making steady progress. The Sanitary Council of Vienna has passed resolutions to the effect that the burning of the bodies of the dead is the safest mode of preventing the evils of earth burial. It has been decided by the Bombay Municipal Corporation to grant the request of an Englishman to be allowed to erect a crematorium for Europeans in the municipal burying ground. The Corporation has granted a plot of ground measuring 40 feet square for that purpose, at a nominal rent of one rupee per annum. The condition attached is to the effect that the crematorium shall be removed at one month's notice if the Corporation so requires.—*Brit. Med. Jour.*

MEDICAL CHEMISTRY.

CALCIUM SALICYLATE.

This salt is now being used alone or with bismuth salicylate as a remedy for diarrhœa and gastro-enteritis. The following formula for its preparation is suggested by Herr Vonjescu in *Zeit. Ost. Apot. Ver.*, page 630: Dissolve 200 grams sodium salicylate in 5000 grams distilled water, filter, add 10 grams solution soda sp. gr. 1.160. Make a separate solution of 100 grams of calcium carbonate by means of dilute acetic acid to neutrality, filter and add slowly to the former solution. Wash the precipitate on a filter to free it from sodium acetate and dry at 35° C. (95° F.) and keep in well-closed bottle. It is a white, odorless and tasteless crystalline powder soluble in cold water 1 in 2000, readily soluble by means of carbonated water or by dilute acids. Dose, 0.5–1.5 grams.

NEW REAGENTS FOR COPPER SALTS.

Le Moniteur de la Pharmacie (1891, 1006) states that pyrogallic acid and a cold solution of neutral sulphate of sodium yield with small quantities of copper salts a blood red color. I cc. of a solution of copper sulphate, $\frac{1}{10000}$, still shows the reaction.

Mr. Deniges evaporates the solution to be analyzed, to dryness, and adds to the calcined residue one drop of a 5 per cent. solution of bromide of potassium. The mixture is again evaporated to dryness when, if copper be present, a characteristic violet zone of anhydrous copper bromide appears.

NEWS AND MISCELLANY.

School Trustee.—"Your class in physiology does not appear to be up to the standard, Miss Birch.

Teacher.—"I've done the best I could with the charts that I found here, Mr. Small."

School Trustee.—"Um–er–what did the charts consist of?

Teacher.—"Six views of a whiskey stomach."

—*Puck.*

EFFECT OF DYNAMITE ON FISH.

M. Regnard recently read notes on this subject before the Société de Biologie de Paris. A cartridge containing thirty grammes of dynamite was exploded in a pond full of fish. The fish which were closest to the cartridge were annihilated, those farther off lay motionless on the surface. They were not, however, dead, for even when touched very gently they recovered their usual agility and disappeared. This fact is known to poachers, who catch the fish stunned in this manner in a landing net, taking care not to touch it until it is fairly in the net. M. Regnard suggests that the vibrations set up by the violent explosions are transmitted to the nerve centres, and produce effects similar to those seen in man in cases of mine explosions and railway accidents.—*Brit. Med. Jour.*

Suppose we find the patient a little giddy upon rising in the morning. This means that the nerves do not have perfect control of the muscular system. As a test for this, direct the patient to stand with his feet close together, shut his eyes, and if the tendency is to reel, it is another evidence of lowered nerve tone. Or, stand with the arms extended, shut the eyes, and then try to bring the tips of his forefingers together in front of him. If they pass by or meet imperfectly, it shows the same thing.

Or, the person may not be able to think as quickly as he should. To test this, ask the patient three simple questions in rapid succession, as, Where were you just before you came into this room? What were you doing? How long did you remain? The rapidity with which the answers are given indicate the rapidity of brain action.

All these things show that it is of the utmost importance that the nervous system should be kept in tone. Otherwise, every part of the body languishes.

This condition indicates the use of Celerina (Rio) in teaspoonful doses four times a day, *to increase the nerve capital of your patient.*

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